Iowa Department of Human Services

Mental Health System Redesign

Children's Disability Workgroup

Discussion Paper # Four: Children's Health Homes—A Model of Care for System Transformation

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I. Introduction

Proposed for consideration by the Children's Disability Workgroup is the development of a Children's "Health Home" model for service delivery. As of January, 2011 States have the option to provide health home services to Medicaid beneficiaries with chronic conditions.[1] The CMS standards require that health homes have the capacity for a "whole person" approach to care. To be eligible for health home services, a person must have:

- Two chronic conditions (including asthma, diabetes, heart disease obesity, mental condition, substance use disorder) OR
- One chronic condition and at risk for another OR
- One serious and persistent mental health condition

Per Section 1945(h)(5) of the Act, examples of providers that may qualify as a "designated provider" include physicians, clinical practices or clinical group practices, rural health clinics, community mental health centers, home health agencies, or other entity or provider that is deemed appropriate by the State and approved by the Secretary.

In concert with the overall mental health system redesign, the Workgroup is asked to consider how Health Homes for children would relate to the envisioned Regional service structure and how partnerships might form between children's mental health service providers and child medical care providers such as Child Health Specialty Clinics.

[1] Described in section 2703 of the Affordable Care Act, entitled "State Option to Provide Health Homes for Enrollees with Chronic Conditions

II. Rationale

As described in a November, 2010 letter to State Medical Directors from CMS, "The health home provision authorized by the Affordable Care Act provides an opportunity to build a person-centered system of care that achieves improved outcomes for beneficiaries and better services and value for State Medicaid programs. This provision supports CMS's overarching approach to improving health care through the simultaneous pursuit of three goals: improving the experience of care; improving the health of populations; and reducing per capita costs of health care (without any harm whatsoever to individuals, families, or communities)."

The consideration of a Health Home model for children aligns with many of the attributes of a transformed system that have been identified by Workgroup members. The model could:

- Bring a comprehensive care coordination component to the delivery of services to children that has largely been absent
- Forward a "whole-health" approach for children
- Promote services that are individualized, flexible, nimble and family/youth-centered
- Aid in achieving the vision of the Olmstead state plan by assuring families a choice of comprehensive community-based services for children with complex and high-risk healthcare and support needs.
- Focus attention on systemic outcomes that include needs not always well addressed by the treatment system—succeeding in school, preparing for employment, feeling a part of the community, having meaningful social connections
- Expands choices for families

Other considerations:

- States will receive temporary (first eight fiscal quarters) enhanced FMAP at 90% and technical assistance in setting up the plan is provided by CMS
- Medicaid "comparability" requirement is waived, so the program can offer flexibility in scope, duration and target population and build the service incrementally
- Planning for implementation can (roughly) coincide with the move of PMICS under managed care and the shift of county-based service system to a regional model

III. How would new (enhanced) core services be delivered under a Health Home model?

The Children's Workgroup identified new (enhanced) services for treating children and families in their homes, schools and communities. Here is how two of those services might be incorporated into a Health Home model:

1. Care Planning and Service Coordination—This would be (and is required by CMS) a primary responsibility of a Health Home and includes:

    - Individualized Care Plan that coordinates and integrates all clinical and non-clinical services and supports to address the person's health-related needs (whole-person)
    - Coordinating and providing access to mental health, substance use, preventative and health promotion services
    - Comprehensive care management including care coordination, transition across care settings (including offering comprehensive coordination and support to PMICs and other facilities), and chronic disease management
    - Individual and family supports including referrals to community and social supports
    - Establish a continuous quality improvement program focused on both individual and population-level outcomes and to pay attention to key outcomes such as avoidable hospitalization, lower rates of ED use, and community tenure.
    - The use of Health Information Technology to link services and coordinate care.

    In addition, the Health Home could have responsibility for leading in regional systems of care planning processes, workforce development, development of cross-system/cross-service referral pathways, linkages, information exchange, services collaborations.

2. Family Peer Support/Navigator—A member of the Health Home care planning team, a Family Support Specialist or Family Partner[2] would lead in assuring that care is family-centered and culturally appropriate, offers competency to the team in understanding and considering family journey, voice and choice. In addition, this team member would serve as support, ally, advocate, navigational assistant as identified with and desired by the child and family.

IV. A Tiered-Approach

The way CMS has structured the Health Home option, States may choose to have tiers of eligibility and service intensity. The Workgroup will be asked to consider a three-tiered

[2] "Family Support Specialist" and "Family Partner" are titles used in other jurisdictions to describe care providers who bring to their positions personal experience as parent or caretaker of a child with mental health conditions and experience navigating the child-serving system on the child and family's behalf.

Health Home model provides graduated services and care-coordination based on a combination of diagnoses, co-existing conditions and functional impairments.

States are permitted to establish a tiered payment system and have flexibility in proposing payment methodology. Payment could be fee for service or a tiered, per member per month capped rate.

V. Preparation for Workgroup Session

In preparation for the October 11, 2011 Workgroup meeting, Members are asked to consider:

1. A Health Home model of service delivery for children and families
2. Building the Health Home as a partnership between child mental health and child medical health services providers
3. The relationship of the Health Homes to the envisioned regional structure
4. Delivery of new (enhanced) services under proposed Health Home framework
    a. Care Planning and Service Coordination
    b. Family Peer Support/Navigator Service
5. Relationship to/coordination with other services to children
    a. BHIS services
    b. Crisis Services
    c. PMIC services
6. Tiered approach to care management
    a. Service delivery
    b. Payment methodology